County of San Diego
Department of Environmental Health
OCEAN ILLNESS SURVEY

Your response is important in evaluating illnesses contracted through ocean water contact in San Diego County. Please fill out the form as accurately as possible. Completed surveys may be faxed to 858-694-3670, or mailed to County of San Diego DEH, Recreational Water Program, P.O. Box 129261, San Diego CA 92112-9261

Respondent Information (Personal information will be kept confidential)

Name _____ **Phone number** _____ **May we contact you?** Yes No

Age _____ **Gender M / F** **City / Zip** _____

1. On average, how often do you go into the water? (Check one)

- ❑ Less than twice a year
- ❑ Once every 1 – 6 months
- ❑ 1 – 2 times per month
- ❑ 3 - 4 times per month
- ❑ About once a week
- ❑ More than once a week

2. What is your primary means of water contact? (Check one)

- ❑ Surfing
- ❑ Swimming
- ❑ Ocean Craft / Jet Ski
- ❑ Scuba / Snorkeling
- ❑ Sailboarding
- ❑ Mixed (Variety of Uses)
- ❑ Other (specify) _____

3. What times of the year are you typically in the water? Year-round Summer only Winter only

4. In the past year, have you become ill from ocean water contact in San Diego County? Yes No

Use the remainder of this form to describe any illness you contracted which you believe to be related to ocean water contact. If you are reporting more than one illness, please complete a separate form for each.

Exposure Information

5. Date of water contact (include any dates up to two weeks prior to illness)_____

6. How much water did you swallow?
None Less than 6oz More than 6oz

7. Location (beach name, break, etc.) _____

_____

Illness Information

8. What types of symptoms did you experience? (Check all that apply)

- ❑ Respiratory / Sinus (congestion, coughing, etc.)
- ❑ Diarrhea
- ❑ Vomiting
- ❑ Fever
- ❑ Eye (discharge, pink eye, etc.)
- ❑ General malaise or fatigue (excessively tired, etc.)
- ❑ Sore Throat / Swollen Glands
- ❑ Upset Stomach
- ❑ Headache
- ❑ Ear (discharge, pressure, etc.)
- ❑ Skin (rash, etc.)
- ❑ Other (specify) _____

9. What date did these symptoms appear?

_____

10. Did you see a doctor? Yes No
If yes, what was the doctor's diagnosis? _____

_____

Comments _____

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